State of Montana
Health Care and Benefits Division

PO Box 200127
Helena MT 59620

1-800-287-8266
444-7462 in Helena

DECLARATION OF TAX STATUS – RESPONSE REQUIRED BY 10/16/06

The State of Montana is required by the Internal Revenue Service to apply the proper tax treatment (before or after tax) to benefits for every family member currently enrolled in medical, dental, or vision benefits. Therefore, it is important that you provide the tax status of each person enrolled. The qualification of these individuals as your spouse and/or dependent(s) for tax purposes does not affect their eligibility for the medical, dental or vision plans, but does impact the tax treatment of that coverage. The attached flowcharts are provided to assist you in determining and verifying the tax status of your family members.

List below each dependent enrolled in medical, dental or vision benefits. Check one of the two boxes next to each name and return this form to the address above by October 16, 2006. ***If you do not check a box or respond by the deadline, premium contributions for those persons will be taken on an after-tax basis and the fair market value of the benefits provided by the State of Montana (i.e., those benefits funded through the state share) for these persons will be added to your taxable income.*** The attached flowcharts provide the most complete overview of the tax rules possible; however, given the complexity of those rules, we recommend that you consult with your tax advisor regarding your specific circumstances.

Spouse: _____

- ☐ Yes, this person is my spouse for tax purposes.
- ☐ No, this person is not my spouse for tax purposes.

CHILD: _____

- ☐ Yes, this person is my child for tax purposes.
- ☐ No, this person is not my child for tax purposes.

CHILD: _____

- ☐ Yes, this person is my child for tax purposes.
- ☐ No, this person is not my child for tax purposes.

CHILD: _____

- ☐ Yes, this person is my child for tax purposes.
- ☐ No, this person is not my child for tax purposes.

CHILD: _____

- ☐ Yes, this person is not my child for tax purposes.
- ☐ No, this person is not my child for tax purposes.

FINISH FORM ON BACK

CHILD: ______________________________

☐ Yes, this person is my child for tax purposes.

☐ No, this person is not my child for tax purposes.

CHILD: ______________________________

☐ Yes, this person is my child for tax purposes.

☐ No, this person is not my child for tax purposes.

CHILD: ______________________________

☐ Yes, this person is my child for tax purposes.

☐ No, this person is not my child for tax purposes.

CHILD: ______________________________

☐ Yes, this person is my child for tax purposes.

☐ No, this person is not my child for tax purposes.

CHILD: ______________________________

☐ Yes, this person is my child for tax purposes.

☐ No, this person is not my child for tax purposes.

CHILD: ______________________________

☐ Yes, this person is my child for tax purposes.

☐ No, this person is not my child for tax purposes.

CHILD: ______________________________

☐ Yes, this person is my child for tax purposes.

☐ No, this person is not my child for tax purposes.

With respect to any person for whom you have checked "No," premium contributions for those persons cannot be taken on a pre-tax basis and the fair market value of the benefits provided by the State of Montana (*i.e.*, those benefits funded through the state share) for these persons will be added to your taxable income.

I understand that the State of Montana has a legitimate need to confirm whether my spouse, domestic partner and/or any covered children meet the appropriate definition(s) for tax purposes for the medical, dental and/or vision plans. I certify that the information I have listed above is true. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I agree to notify the ***Health Care and Benefits Division*** *if there is any change in these circumstances within thirty (30) days of the change. I am aware that changes may impact the tax treatment of my coverage.*

______________________________	______ - ______ - ______
Printed Name of Employee	Social Security Number
______________________________	______________________
Signature of Eligible Employee	Date

ADMINISTRATIVE USE ONLY

System Entry Date______________________ Entered By____________________________